ND Provider Questions to ND Medical Assistance
04/12/2006 Meeting

1. **Manual Update:**

Response: ***The Manual update is coming along as planned. We will be adding guidelines to the manual to help the providers determine if a given piece of equipment may or may not be allowed.***

2. **Fee Schedule Update:**

Response: ***We are also in the process of updating.***

3. **HCPC Code K0462** – At the present time this code is not recognized by ND Medical Assistance. On all priors we are told to submit with the base code of the pt. Owned equipment. All primary insurance carriers require us to use K0462, so if this claim automatically crosses over from Medicare it will deny for no prior auth. It is then up to the provider to manually resubmit this. This causes unnecessary delays and work for the provider to get paid. What can your department do to correct this?

Response: ***We require definitive codes. It is the decision of NDMA not to recognize this code alone. If you are using this code, you will need to couple this code with the specific code to the piece of equipment you are renting and the appropriate RR modifier. Example: Replacement of a manual wheelchair (K0001RR). This decision is not unique to DME providers.***

4. **Prior Auths** – If a prior auth. is denied for needing more information, some providers have been told that if the requested information is not returned to your department within 3 weeks that the prior will deny. If the provider still wants to provide the equipment they have to do a whole new prior through reconsideration's.
    a. Where is this stated in writing, and why have only some been notified of this? If this is a process that you wish to incorporate then a bulletin should be issued to all providers.
    b. By initiating this, you are placing time limits on the provider that sometimes cannot be helped. The physician may not complete the paperwork, or perhaps we cannot get medical records within that time. Why should the provider be penalized by making them do more paperwork? Why should it be so hard to receive an approval form you department?

Response: ***It is the responsibility of the DME providers and NDMA to supply our clients their medically necessary equipment in a timely manner. DME providers are responsible to make an effort to get the requested information from physicians and facilities within this time frame for the benefit of our clients.***

5. **Has there been any reconsideration on your payment on the high-end rehab chairs that we provide?** We have had this on the agenda for previous meetings and have been told that this would be reconsidered in the future. The payment that we receive (20% over our cost) is not close to what it is costing us to provide these chairs. You have to take into consideration the time spent in evals., fitting, paperwork etc. In addition, we were told that allowables would be created for these codes; to date we have not received any information on this. This makes it extremely hard for the provider because they have no way of knowing what the reimbursement will be for a particular item.

Response: ***Limited to medically necessary items delivered in the most appropriate and cost effective manner. See Manual (Page 8 section E)***

6. **Is there a way that you can inform us on a monthly basis how far you are behind in processing claims?** Some providers have been told that they cannot request information on a specific claim unless it is 90 days out. Previously we were told that you were at 30 days. If we cannot check on a claim until it is 90 days out, then apparently you are no longer processing within 30 days. Providers need to have a way of knowing when they will be paid for the items that they provide. Is there a bulletin that could be sent alerting us to your claim processing status?

Response: ***A bulletin indicating the claims processing status is not possible. If an extraordinary circumstance occurs that significantly affects the claims processing turnaround time, we will notify providers. If a clean claim is submitted, 30 days for a status check is appropriate. If the claim requires review and is not a "clean claim", it may take longer than 30 days for the claim to be paid. We are currently not behind in claims.***

7. **Can you or will you put "in writing" your guidelines for coverage of oxygen?** You have now informed us that you require saturations and that you follow Medicare guidelines for coverage. We do our best to provide services to your beneficiaries, but in the past you never asked for this data. Now you are requesting it and we are getting rejected because the saturation level wasn't low enough. If we had known you were knew you were going to look at Medicare guidelines, we would have questioned the saturation. But, we have done what we have always done—provided off of a prescription and didn't question the physician, because in the past YOU didn't question us.

   Please understand, we are okay if the guidelines have been put in place properly, and we didn't follow them. However, there were no previous guidelines by your department and we provided oxygen based off the prescription because the physician felt it was medically necessary. With other insurances I have guidelines to show them what is required in order for coverage. I have nothing to show them

that states your guidelines. This makes it difficult to go back and tell them that what they have ordered for years is no longer good enough.

Response: ***Our current oxygen guidelines primarily follow Medicare guidelines.***

8. **When a beneficiary has a primary insurance carrier with Medicaid secondary, and the Doctor only orders the rental of a nebulizer. The patient may only need it for one month. What are the providers suppose to bill to you, since you only purchase the?** We run into this being an issue when we have patients and the primary insurance applies to the deductible and you won't pay for the sale based on the diagnosis and you won't rent it because that is your policy…so now as a provider, I gave it to the patient for free. Can't there be some individual consideration for these issues? OR are you telling me that I can bill the patient the remaining amount because you don't cover the rental?

Response: ***This will also be addressed in the new manual. If a primary payer's policy is to rent the item, NDMA will also rent up to 12 months. If Medicaid is the primary payer, then the NDMA will determine if rental or purchase is in the best interest of the department/client.***

9. **Prior Approval Notification from NDMA that you will not refax or resend approval notices Total responsibility is on the Provider.**
    a. Regarding the yellow sheet notifications that approval notices will not be resent. Sometimes problems cannot be avoided, why are we penalized again for something that we should be able to work together on. Again, this policy was put in place without prior notification to the providers so they have a chance to put a process in place for receipt of all prior auths BEFORE it goes into effect. Consequently, it has caused problems for us in timeliness of receiving payment and/or having the claim processed.
    b. If this problem was provider specific, why couldn't your agency discuss the problem with that provider individually and have them correct their internal problems?

Response: ***For the last 2 years, NDMA has not re-faxed or resent responses to providers concerning approvals or denials. The requests for re-faxing were increasing. When NDMA looked into the reasons this was happening, it was verified that the DME requests had been processed and returned to your facility. This is not a new policy.***

10. **NDMA reimbursement rates are 20% over our acquisition cost. This is to cover costs for ordering, shipping, receiving, set-up costs, and billing.** Currently NDMA is approving the cost of CPAP and BiPAP for a 3-month trial period and if tolerated, will approve purchase of a new unit after the rental period. When the new unit is approved for purchase by NDMA, all their required rental payments are then applied towards the purchase price of the new unit. If their requirement is that we have to rent for a trial period prior to purchasing a new CPAP or BiPAP unit, there should be no rental billing applied to the purchase. A

rental and purchase are not in the same category. None of us are a rent-to-own type of business. Operating a business in this fashion is like a car dealership allowing their customers to rent a car for 3 months and then taking that rental cost off the purchase price of a new car. I'll bet we won't find a dealership like that anywhere around here. Please consider our costs involved in renting equipment such as servicing, cleaning, maintaining accurate records, billing each month, etc., verses the cost of a one time sale from the beginning. Our costs are, at a minimum, barely covered with reimbursement rates of only 20% over acquisition cost.

Response: ***NDMA will continue to operate using our current policy and will continue to apply rental towards purchase. This again will be addressed in our new DME Manual.***

11. **Over the past several months we have heard via radio and television that the state of ND's budget is well into the black.** Per the media it shows an excess into the millions of dollars. If this is the case, where or what does a DME provider have to do, to gain access to some of this funding so that we can better service your beneficiaries? All we have heard over the past few years is that the budget was cut and there is no money for these items, yet the reports we hear statewide is that there is no monetary shortage? We understand that this money is budgeted to many different departments, but what options do we have so that some of this could be considered for the DME industry and your beneficiaries?

Response: ***Any budget requests, questions or concerns need to be put in writing and addressed to Maggie Anderson, Director of Medical Services.***

12. **One of the things that comes to mind is the labor reimbursement. We have been seeing a $200 max no matter how complex the system is or how many hours (units) are billed. When the 20% over cost thing was introduced, we were told by Dan to bill out our actual labor (assessment, fitting, assembly, writing up eval. time, any time we spent on the client) as that is where we could make up some dollars to offset the huge cuts in the equipment reimbusement. I don't know if others have noticed this. I asked Dan and he stated there was the cap of $200 and didn't recall the previous conversations of actual time.**

Response: ***Labor reimbursement was never meant to "make up some dollars to offset the huge cuts in equipment reimbursement." A cap was established over a year ago.***

In reviewing many of these questions, I believe that a lot of these issues could be resolved if your agency notified all providers of any policy changes or updates via email or bulletin prior to the implementation date. This is done by all other insurance carriers, and it gives the provider a chance to prepare for the change.

Many times this preparation requires us to notify physicians, staff, and patients as well as putting a process into place within our own company(s). By just changing something without this proper notification only causes frustration on behalf of all of us, because we are at a loss as to what we can and cannot do.